

administrative and judicial review in accordance with § 412.77(h).

(i) *Modification of hospital-specific rate.* The intermediary recalculates the hospital-specific rate determined under this section in the manner set forth in § 412.77(i).

(j) *Maintaining budget neutrality.* CMS makes an adjustment to the hospital-specific rate determined under this section in the manner set forth in § 412.77(j).

[73 FR 48754, Aug. 19, 2008, as amended at 75 FR 50414, Aug. 16, 2010]

**§ 412.79 Determination of the hospital-specific rate for inpatient operating costs for Medicare-dependent, small rural hospitals based on a Federal fiscal year 2002 base period.**

(a) *Base-period costs*—(1) *General rule.* Except as provided in paragraph (a)(2) of this section, for each MDH, the intermediary determines the MDH's Medicare Part A allowable inpatient operating costs, as described in § 412.2(c), for the 12-month or longer cost reporting period beginning on or after October 1, 2001, and before October 1, 2002.

(2) *Exceptions.* (i) If the MDH's last cost reporting period beginning before October 1, 2002, is for less than 12 months, the base period is the MDH's most recent 12-month or longer cost reporting period beginning before that short cost reporting period.

(ii) If the MDH does not have a cost reporting period beginning on or after October 1, 2001, and before October 1, 2002, and does have a cost reporting period beginning on or after October 1, 2000, and before October 1, 2001, that cost reporting period is the base period unless the cost reporting is for less than 12 months. In that case, the base period is the MDH's most recent 12-month or longer cost reporting period beginning before that short cost reporting period.

(b) *Costs on a per discharge basis.* The intermediary determines the MDH's average base-period operating cost per discharge by dividing the total operating costs by the number of discharges in the base period. For purposes of this section, a transfer as described in § 412.4(b) is considered to be a discharge.

(c) *Case-mix adjustment.* The intermediary divides the average base-period cost per discharge by the MDH's case-mix index for the base period.

(d) *Updating base period costs.* For purposes of determining the updated base-period costs for cost reporting periods beginning in Federal fiscal year 2002, the update factor is determined using the methodology set forth in § 412.73(c)(14) through (c)(16).

(e) *DRG adjustment.* The applicable hospital-specific cost per discharge is multiplied by the appropriate DRG weighting factor to determine the hospital-specific base payment amount (target amount) for a particular covered discharge.

(f) *Notice of hospital-specific rate.* The intermediary furnishes the MDH a notice of its hospital-specific rate which contains a statement of the hospital's Medicare Part A allowable inpatient operating costs, number of Medicare discharges, and case-mix index adjustment factor used to determine the hospital's cost per discharge for the Federal fiscal year 2002 base period.

(g) *Right to administrative and judicial review.* An intermediary's determination of the hospital-specific rate for a hospital is subject to administrative and judicial review. Review is available to an MDH upon receipt of the notice of the hospital-specific rate. The notice is treated as a final intermediary determination of the amount of program reimbursement for purposes of subpart R of part 405 of this chapter, governing provider reimbursement determinations and appeals.

(h) *Modification of hospital-specific rate.* (1) The intermediary recalculates the hospital-specific rate to reflect the following:

(i) Any modifications that are determined as a result of administrative or judicial review of the hospital-specific rate determinations; or

(ii) Any additional costs that are recognized as allowable costs for the MDH's base period as a result of administrative or judicial review of the base-period notice of amount of program reimbursement.

(2) With respect to either the hospital-specific rate determination or the

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amount of program reimbursement determination, the actions taken on administrative or judicial review that provide a basis for recalculations of the hospital-specific rate include the following:

(i) A reopening and revision of the MDH's base-period notice of amount of program reimbursement under §§ 405.1885 through 405.1889 of this chapter.

(ii) A prehearing order or finding issued during the provider payment appeals process by the appropriate reviewing authority under § 405.1821 or § 405.1853 of this chapter that resolved a matter at issue in the MDH's base-period notice of amount of program reimbursement.

(iii) An affirmation, modification, or reversal of a Provider Reimbursement Review Board decision by the Administrator of CMS under § 405.1875 of this chapter that resolved a matter at issue in the hospital's base-period notice of amount of program reimbursement.

(iv) An administrative or judicial review decision under § 405.1831, § 405.1871, or § 405.1877 of this chapter that is final and no longer subject to review under applicable law or regulations by a higher reviewing authority, and that resolved a matter at issue in the hospital's base-period notice of amount of program reimbursement.

(v) A final, nonappealable court judgment relating to the base-period costs.

(3) The adjustments to the hospital-specific rate made under paragraphs (h)(1) and (2) of this section are effective retroactively to the time of the intermediary's initial determination of the rate.

(i) *Maintaining budget neutrality.* CMS makes an adjustment to the hospital-specific rate to ensure that changes to the DRG classifications and recalibrations of the DRG relative weights are made in a manner so that aggregate payments to section 1886(d) hospitals are not affected.

[71 FR 48137, Aug. 18, 2006, as amended at 75 FR 50414, Aug. 16, 2010]

## 42 CFR Ch. IV (10–1–12 Edition)

### Subpart F—Payments for Outlier Cases, Special Treatment Payment for New Technology, and Payment Adjustment for Certain Replaced Devices

#### PAYMENT FOR OUTLIER CASES

#### § 412.80 Outlier cases: General provisions.

(a) *Basic rule*—(1) *Discharges occurring on or after October 1, 1994 and before October 1, 1997.* For discharges occurring on or after October 1, 1994, and before October 1, 1997, except as provided in paragraph (b) of this section concerning transferring hospitals, CMS provides for additional payment, beyond standard DRG payments, to a hospital for covered inpatient hospital services furnished to a Medicare beneficiary if either of the following conditions is met:

(i) The beneficiary's length-of-stay (including days at the SNF level of care if a SNF bed is not available in the area) exceeds the mean length-of-stay for the applicable DRG by the lesser of the following:

(A) A fixed number of days, as specified by CMS; or

(B) A fixed number of standard deviations, as specified by CMS.

(ii) The beneficiary's length-of-stay does not exceed criteria established under paragraph (a)(1)(i) of this section, but the hospital's charges for covered services furnished to the beneficiary, adjusted to operating costs and capital costs by applying cost-to-charge ratios as described in § 412.84(h), exceed the DRG payment for the case plus a fixed dollar amount (adjusted for geographic variation in costs) as specified by CMS.

(2) *Discharges occurring on or after October 1, 1997 and before October 1, 2001.* For discharges occurring on or after October 1, 1997 and before October 1, 2001, except as provided in paragraph (b) of this section concerning transfers, CMS provides for additional payment, beyond standard DRG payments, to a hospital for covered inpatient hospital services furnished to a Medicare beneficiary if the hospital's charges for covered services, adjusted to operating costs and capital costs by applying cost-to-charge ratios, as described in